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ABSTRACT

Under the State Child Health Insurance Program, states receive funds to purchase health insurance for low-income, uninsured children. Noting that partnering with managed care will be essential if school-based health centers are to receive reimbursement for serving the publicly insured portion of their clientele, this paper examines the relationship between this public insurance program and school-based health centers (SBHCs). The paper first describes the establishment of SBHCs in the early 1970s and their expansion, focusing on the financing mechanisms used. The paper then describes the State Child Health Insurance Program, including the views of federal and state agencies, health plans, and local SBHCs on the challenges of developing contracts, the incentives and disincentives health plans have to contract with SBHCs, and what has accounted for success where relationships are moving forward. Finally, the paper presents case studies on the experiences of Colorado and Connecticut in addressing these evolving issues. (KB)

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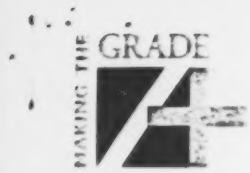

STATE AND LOCAL PARTNERSHIPS TO ESTABLISH SCHOOL-BASED HEALTH CENTERS

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The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?

A report from a workshop sponsored by

Making the Grade: State and Local Partnerships to Establish School-based Health Centers

The National Assembly on School-Based Health Care

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The New Child Health Insurance Expansions:
How Will School-Based Health Centers Fit In?

Abstract
In June, 1998, the Making the Grade National Program Office and the National Assembly on School-Based Health Care sponsored a workshop on the relationship between the State Child Health Insurance Program (SCHIP) and school-based health centers. Workshop participants used the health centers' experience with Medicaid managed care as a window for understanding their prospects for negotiating contracts with health plans under SCHIP. Speakers representing the federal perspective, state agencies, health plans, and local school-based health centers offered their views on the challenges of developing contracts, the incentives and disincentives health plans have to contract with school-based health centers, and what has accounted for success where relationships are moving forward. Experiences in Colorado and Connecticut were presented as case studies on these evolving issues.

School-based health centers have emerged as part of the provider network that serves uninsured and publicly insured children. Today, the centers' ability to care for these children lies increasingly on their success in contracting with managed care plans as providers. Because of the sizable Medicaid population seen by the centers, the transformation of Medicaid from a fee-for-service to a managed care model has required the centers to forge relationships with managed care plans. Last year's enactment of the State Children's Health Insurance Program (SCHIP), and the likelihood that managed care will be the dominant model of serving children under this program, leaves little doubt that partnering with managed care will be essential if school-based health centers are to receive reimbursement for serving the large portion of their clientele who are, or will be, publicly insured.

To explore the future of school-based health centers in a world increasingly dominated by managed care, the Making the Grade National Program Office joined with the National Assembly on School-Based Health Care in June, 1998 in sponsoring a workshop on SCHIP and school-based health centers. The session provided a federal overview presented by Doris Barnette, senior advisor to the administrator of the federal Health Resources and Services Administration (HRSA), the US Department of Health and Human Services (HHS) office concerned with health services delivery. Abigail English, an attorney with the National Center for Youth Law, mapped SCHIP implementation across the states and pointed out opportunities that school-based health centers might seek out as these programs are developed at the state level. State officials as well as representatives from school-based health centers and managed care plans from the two featured states described their experiences in the negotiation process. Additional comments from a plan perspective were offered by officials from two Los Angeles-based health plans as well as the President of the National Assembly, Karen Hacker, MD.

Background

School-based health centers were established in the early 1970s with the goals of making health care more accessible to adolescents and reducing the incidence of their behavior-related health problems, including teen pregnancy. Over the past 25 years the centers have expanded, increasing from a handful in the early 1980s to more than a thousand in 1998. While the largest number of health centers are located in high schools (38 percent), about 33 percent are housed in elementary schools, and 16 percent are in middle schools[1].

Until recently, school-based health centers have remained mostly outside mainstream financing mechanisms, including Medicaid. They have depended on local, state, and federal grants, as well as private funding from foundations and hospitals. The uncertainty of these funding sources and the limitations of their availability, combined with the national trend toward market-driven health care financing, has led school-based health centers to seek reimbursements from third party payers, including Medicaid and commercial insurers.

Third party payments, particularly Medicaid funding, have represented a small but growing portion of school-based health center revenues. In 1998 15 states estimated more than $8 million in Medicaid payments to centers.[2] Findings from a number of small-scale surveys conducted over the past three years show that Medicaid revenues, on average, have represented under 10 percent of operating costs for most school-based health centers[3], but some have reported recouping about a third of their budgets from Medicaid.[4]

Recently managed care has emerged as the middleman between community providers and the state Medicaid agency, making it more difficult for centers to bill Medicaid for serving its beneficiaries. While some states have required or encouraged health plans to contract with school-based health centers as providers, in most states the onus has been placed on centers or their sponsors to establish relationships with plans in order to retain a place as a Medicaid provider.

Forty-eight states now rely on some type of managed care to serve Medicaid beneficiaries. The Health Care Financing Administration reports that between 1991 and 1997, Medicaid enrollment in managed care grew five-fold, with 48 percent of the approximately 32 million Medicaid recipients enrolled in managed care in 1997 -- most of them low-income children and their parents.[5] Use of full-risk managed care plans in Medicaid is quickly increasing and is now the dominant model of Medicaid managed care, but penetration rates vary widely among the states. Penetration is deepest in the Mid-Atlantic and Pacific states, and lower in the south-central and South-Atlantic regions of the country. In 1996, 87 percent of Medicaid enrollees in HMOs lived in just 16 states, and 15 states had no full-risk plan serving Medicaid.[6] Clearly, however, the prospects of school-based health centers being reimbursed directly by their state Medicaid agency on a fee-for-service basis are dwindling.

States using managed care arrangements to serve children on Medicaid will most likely use the same model to deliver care to SCHIP enrollees. Because the SCHIP legislation seeks to recruit eligible children into both SCHIP and Medicaid, more children can be expected to receive services under managed care. A new Clinton administration outreach directive, private foundation investment in outreach programs, and the law's incentive for states to quickly expand Medicaid eligibility to older adolescents promises to swell the rolls of Medicaid and SCHIP.

The State Child Health Insurance Program. Under SCHIP, Congress has authorized $40 billion over ten years for states to purchase health insurance for low-income uninsured children -- the largest federal investment in child health since the Medicaid program. An estimated 33 percent, or about 3 million, of all uninsured children will be eligible for coverage under the new program.[7] Its potential for school-based health centers is great. Especially in middle schools and high schools, where many low-income children have been too old to qualify for Medicaid or not quite poor enough, health centers often report that about half the children they care for are uninsured.

Essentially, SCHIP funds are divided into two categories: administrative dollars and insurance dollars. Administrative dollars total ten percent of a state's SCHIP allocation; they are to be used to fund program costs including marketing, enrollment, data management, and/or direct care providers, which can include school-based health centers.

Few states expect to funnel substantial dollars to providers from their "ten percent" funds. The bulk of dollars will pay for insurance provided to program beneficiaries, and in many cases the insurance will be provided by a managed care plan. For school-based health centers to participate in SCHIP, they will need to have contractual relationships with participating plans.

The HRSA Vision

Doris Barnette emphasized the determinative role of state governments in shaping the new child insurance program. Other than federal review of initial state plans, the SCHIP legislation does not preserve a role for the federal government in decisions about which providers should participate and at what payment rate.[8]

"While we're not mandating and we're not dictating, we have failed in our mission if we don't support you in making sure that there are provider networks of which you could and should be an integral part. States are currently consumed with getting their state plans approved and getting children in SCHIP and have not assessed the adequacy of their provider networks."--*Doris Barnette*

However, according to Barnette, HRSA has a two-fold vision for school-based health centers within SCHIP: marketing and enrolling beneficiaries and serving as a provider in the SCHIP delivery system. In addition to outreach and enrollment, Ms. Barnette supported participation by the school-based health centers in SCHIP provider networks. She credited former Health Care Financing Administration chief Bruce Vladeck for arguing, before SCHIP was ever debated, that having an insurance card does not guarantee access to health care and that pro-active efforts should be made to link children to quality care systems. "While we're not mandating and we're not dictating, we have failed in our mission if we don't support you in making sure that there are provider networks of which you could and should be an integral part. States currently are consumed with getting their state plans approved and getting children enrolled in SCHIP and have not assessed the adequacy of their provider networks".

An Advocate's Perspective

Abigail English reviewed the progress states are making in SCHIP plan submission. Of note is that Congress recently extended the deadline for plan submission and approval by one year to Sept. 30, 1999 -- giving states more time to submit their plans and a longer time frame to be able to use fiscal 1998 funds. However, given the speed with which plans are being submitted and approved, most states will not need this extension. As of September 18, 47 states plus the District of Columbia, Virgin Islands and Puerto Rico had submitted plans, with 41 approved by HCFA. Of the 50 applicants, 13 would create separate child health insurance programs, 27 states would expand Medicaid, and ten would combine the two approaches.

English described shared characteristics among the plans. About half of the 27 states that chose to expand Medicaid as of late June indicated that they intended to develop their plans further in the near future. Both she and Barnette described many of these states as having submitted "place holder" plans, meaning that the states submitted the plans in time to draw down fiscal 1998 funds. Most of these plans leave room for advocacy to shape the next phase of SCHIP expansion. "In some cases," noted English, "the state may have already

decided what the next phase is going to be but the legislation may not have been crafted, or the plan amendment may not have been submitted and this is a work in progress. In either case, if you are in one of these states, you should try to have an effect on that process."

One of the advantages of the law's (SCHIP) flexibility is that state plans approved by HHS can be amended and there is essentially no deadline for trying to persuade state policymakers to supplement benefits coverage.

States have been responding to SCHIP's incentive to phase in 14- to 18-year olds at or below the poverty level into Medicaid. Before SCHIP, about half of the states had not included this group in Medicaid. Federal law requires these teens to be fully phased into Medicaid by 2002. To accelerate this process, the SCHIP offers an enhanced Medicaid match rate to those states that choose to cover these children under Medicaid now; the enhanced match is available whether the state goes with a Medicaid expansion or a separate state program under SCHIP. English found that almost every state plan submitted would accelerate the phase-in.

English noted substantial variation in the benefit package among non-Medicaid approaches. A number of plans would place limits on mental health, substance abuse and dental services. She urged advocates to examine their state plan benefit packages to determine the extent to which services offered at school-based health centers would be covered under SCHIP. One of the advantages of the law's flexibility is that state plans approved by HHS can be amended and there is essentially no deadline for influencing a state's benefits coverage.

English suggested several questions useful in defining the scope of school-based health center participation in SCHIP:

- Will school-based health centers have a role in eligibility determination?
- If the state has opted for presumptive eligibility, will school-based health centers be able to determine this?
- What is the impact of capitated systems on the ability of school-based health centers to be paid through SCHIP?
- Will school-based health centers be funded as direct service providers under the states' 10 percent grant allocation?
- To what extent are services provided by school-based health centers covered under the state's SCHIP?

The Experiences of Colorado and Connecticut

Colorado and Connecticut have had the most success in establishing contracts between health plans and school-based health centers. Both states feature sophisticated school based health center networks and substantial managed care penetration. In addition, both have strong health departments that educate health plans, the state Medicaid agency, and school-based health centers about how to include centers in provider networks and that advocate for the inclusion of centers in Medicaid managed care. Connecticut's regulatory strategy requires that health plans develop contracts with the centers, whereas Colorado, which has a more fiscally conservative legislature, strongly encourages, but does not mandate, such relationships.

Connecticut

The Connecticut Department of Public Health (DPH) supports 45 school-based health centers across the state. In 1995, the centers began a transition from state grant support to a combination of funding from public grants and Medicaid managed care contracts. From the beginning of its 1915b waiver in 1995, which mandated enrollment of Medicaid recipients into managed care, the state has required that managed care plans contract with school-based health centers. Centers are categorized by plans as "ancillary providers" within managed care networks and are paid by plans on a fee-for- service basis.

Connecticut began funding school-based health centers in 1985 through the Department of Public Health, with a policy that any school-based health center receiving state grants could not bill for third party payments. By 1993, when DPH found that state grants were not covering 100% of costs, it decided the centers should bill for Medicaid. After some initial opposition, the Department of Social Services (DSS) -- the agency that administers Medicaid -- agreed to support school-based health center participation in Medicaid. By then Medicaid managed care was at the state's doorstep.

In 1995, DSS agreed to require contracts between managed care plans and school-based health centers under the 1915b waiver program. As a result, the 15 sponsors of school-based health centers and 11 health plans that won Medicaid managed care contracts were required to contract with each other. Since the health plans subcontracted separately for dental and mental health services, the number of contracts required between health plans and school-based health centers was more than 100. Despite the challenge of negotiating that number of contracts, nearly all contracts have been finalized.

"What is really important is that the two agencies, DPH and DSS, followed through. It wasn't just 'You have to do this' and then they forgot about it." -- *Lynn Noyes*

Lynn Noyes, director of the state school-based health center program, credited the state's success in facilitating contracts between centers and managed care plans to two factors: (1) ongoing communication between DPH and DSS to address any problems in the contracting process and (2) state threats of sanctions on health plans and school-based health centers that would not contract. DPH held monthly meetings with school-based health centers to understand what barriers they confronted in the contracting process. They communicated this information to DSS which, in turn, met frequently with health plan officials. The newly-established Connecticut Association of School-Based Health Centers (CASBHC) undertook the task of educating health plans about school-based health centers. The Association worked with the state to develop two educational packages for the managed care industry: a pamphlet describing the services school-based health centers provide that are typically reimbursable by insurance; and one listing services health plan enrollees could get through centers that are free to plans. These services, such as group counseling and health education, are available to all health center enrollees but are typically not reimbursable by insurance.

While most parties complied with the contracting requirement, some plans, as well as health center sponsors, resisted DSS threatened to close off Medicaid enrollment for three plans until they signed contracts with school-based health centers, and DPH threatened three center sponsors with loss of state funds for failing to negotiate with plans. "What is really important is that the two agencies, DPH and DSS, followed through," said Noyes. "It wasn't just, 'You have to do this' and then they forgot about it."

Contracting Challenges --A School-Based Health Center Perspective. One of the first important questions to be answered in preparing for the negotiations, according to Stamford school-based health center director Mary Ellen Hass, was 'Can school-based health centers in Connecticut serve as primary care providers?' The state assembly decided against this status because of the many centers closed during the summer and school holidays. Although all school-based health centers have formal links with community-based providers and function as primary care providers for many students, they contract with health plans as *ancillary* providers and are reimbursed on a fee-for-service basis. Looking to the future, Noyes says that DPH may establish a few centers as primary care providers in partnership with the private pediatric groups that now serve as their medical back-ups.

Another challenge was educating plans about the nature of school-based health centers. With leadership from CASBHC, center directors were aggressive in inviting health plan representatives to tour their centers, a process that, Hass noted, had to be done repeatedly because of high staff turnover in some plans. The centers augmented tours with information packets and a video describing their operations.

Hass offered three key pieces of advice to school-based health centers and their sponsors in negotiating with plans:

ELIMINATE PREAUTHORIZATION. The standard plan protocol requires school-based health centers to call a student's primary care provider (PCP) to determine whether a child should be seen at the center or the PCP's office. Persuading the plans to drop their preauthorization requirement took much educating, said Hass. School-based health centers had to explain that such a process would hinder and in some cases block access to care altogether. As Hass explained it, centers did not have the staff to track down PCPs to secure pre-approval for care. The requirement would have either forced the centers to hire new staff to phone PCP offices or risk nonpayment for care every time a PCP could not be reached. School-based health centers banded together and collectively refused to sign contracts that included preauthorization; health plans subsequently eased the requirement. Instead, to ensure continuity of care, both parties agreed that the centers would make a good faith effort to contact a PCP within 72 hours of having seen their patient.

ALLOW ADEQUATE TIME TO SECURE CONTRACT SIGNATURES. The number of persons who may be required to sign a contract on behalf of the school-based health center can slow the contractual process significantly, according to Hass. In Bridgeport, where the Health Department sponsors the school-based health centers, contracts had to be signed by the city attorney, the city council, and the mayor, all of whom did not consider contract signing a priority. Hass's advice is to prepare for this bureaucratic drudgery. "You can see why it took two- and-a-half years for some contracts to go through."

NEGOTIATE CREDENTIALING. The paperwork required to secure credentials for each plan has placed a significant burden on school-based health center staff. Each of the 11 plans have different credentialing criteria and application forms, requiring staff in each center to fill out 11 different credentialing applications -- a process that must be done annually. The state is working to ease this burden. The Medicaid Managed Care Council comprised of state legislators and children's advocates is meeting with health plan representatives to create a uniform credentialing package for centers that all plans would accept.

At the same time, the credentialing process has caused DPH to raise its operating standards for school-based health centers as they relate to mental health providers. Connecticut now

requires mental health providers at school-based health centers to be licensed or supervised by licensed social workers or licensed marriage and family therapy practitioners; licensure was not required previously. When contracts were first discussed, a number of health plans believed the state's Medicaid standards allowing the use of certain allied health professionals as mental health providers were too weak.

Contracting Challenges: A managed care plan perspective . Physician's Health Services (PHS), a health plan participating in the state's Medicaid managed care program, contracts with several school-based health centers. PHS is organized as a Preferred Provider Organization. Under its Medicaid contract, PHS receives per enrollee capitated payments from DSS and contracts with a range of providers who are paid on a per-service basis according to a fee schedule set by PHS.

Catherine Jackson, Director of Government Operations for PHS, noted that her medical director and contracting and operations departments were in the dark about how school-based health centers functioned and stressed that information needs to be provided to health plans to answer the questions most important to them: What benefits are provided? Who provides them? Who is the contracting agent? Complicating matters for the health plans is the fact that the contracting entities range from a school district to a hospital to a health department to a community health center.

The state requirement to contract with school-based health centers aside, Jackson said PHS has benefited from including centers in its network. For instance, Medicaid enrollees are clustered in major cities in Connecticut where school-based health centers are located, so they became convenient providers. Centers were also used as a marketing tool to attract parents who appreciated schools as convenient locations for care. In addition, school health centers helped PHS meet its quality assurance goals for Medicaid-enrolled children. These goals included providing health education, preventive dental care, access to urgent care, and identifying problems early to avoid emergency room use.

"Look at our contract timeline. PHS started in early 1996, got half the school-based health centers signed on by early 1997, and we just signed the last one in April 1998. It has been a long haul ... there is no magic." -- *Catherine Jackson*

Through discussions with the state and school-based health centers, PHS was able to arrive at solutions for the preauthorization and credentialing issues as described by Mary Ellen Hass. The plan also developed a policy for approving codes for SBHC-provided services not included on the plan's code list. Basically, said Jackson, the plan assigned an employee whom school-based health centers could contact to learn how to code those services. In addition, Jackson said PHS shared its list of Medicaid enrollees with school-based health centers because many children the centers served could not identify their health plan.

Jackson advised managed care plans and school-based health centers to prepare for contracting process that is time consuming and requires patience, persistence, and a willingness to try different approaches. PHS eased into including school-based health centers as providers by contracting with just a few, learning how to overcome barriers specific to the centers, and applying these lessons to other school sites. "Look at our contract timeline. PHS started in early 1996, got half the school-based health centers signed on by early 1997, and we just signed the last one in April 1998. It has been a long haul. You need to keep an open mind for what works and remember there is no magic."

Uninsured Children and Youth), a non-Medicaid expansion program requiring modest co-pays and offering uninsured children the state employees benefits. While HUSKY does not mandate school-based health center inclusion in provider networks, as DPH would have liked, DSS made a verbal commitment that the centers would participate. In the meantime, the Medicaid managed care picture has become less complex. Four of the original 11 Medicaid managed care plans dropped out; five of the remaining seven bid for HUSKY contracts. These are plans with which the school-based health centers have already negotiated contracts. In contrast to the Medicaid program, HUSKY will require enrollees to stay with a plan for at least six months before switching; under Medicaid, enrollees could change plans every 30 days.

Noyes believes the experience school-based health centers have in contracting with Medicaid plans will help them in the HUSKY contracting process, and that services the centers offer that compliment the health plan benefit package will attract families. Such "value-added" services include health-oriented classroom presentations, health fairs, and support groups to address various issues such as divorce and bereavement. In terms of future needs and cautions, Noyes mentioned the need for school-based health centers to build the technical capacity to bill under HUSKY and to collect data required by the plans.

Will current contracts be viable in the future? An increase in the numbers of Medicaid and HUSKY-enrolled children in school-based health centers and more effective billing by the centers may lead to substantial growth in center billings to health plans If this occurs, the plans' support for the centers' fee-for- service billings may wane. This is because a number of Connecticut health plans have capitated arrangements with their primary care providers; the plans thus argue that when they pay the capitation rate to primary care providers *and* they pay fee-for-service to school-based health centers, they are paying twice for primary care for children who use the centers. Noyes says health plans agreed to the current arrangement, which may put the plan at-risk for paying twice, because school-based health center billings were not taxing their budgets. The plans may feel differently if these billings increase.

This perception of paying twice for care provided to Medicaid beneficiaries was the reason that Community Health Network, a health plan consisting of several community health centers, resisted contracting with school-based health centers, said Noyes. The plan claimed it was unable to reserve funds to cover school-based health center services while paying PCPs a flat rate to serve the same children. Yleana Sanchez, a state Medicaid staff member, believes this complaint is specious. If children are being served at the centers, then the PCP does not accrue a cost for providing the care, she said. Therefore, she added, the capitated payment the PCP receives from the health plan leaves room for payments to school-based health centers. "You could also argue that EPSDT rates for teens are so low [in Connecticut] that we're paying too much for PCPs," she mused.

Catherine Jackson of PHS suggested another avenue to explore: allowing centers to remain ancillary providers and creating a cap for them based on an established set of services they would provide. In either case, accepting capitation means that a school-based health center assumes the risk of absorbing the cost of any care that may exceed the level of a cap.

The Colorado Experience

Colorado is a pro-business, anti-tax, anti-regulatory state rooted in strong Republican fiscal conservatism, as described by Bruce Guernsey, director of the state school-based health

program. Given this political environment, it is not surprising that health plan contracting with school-based health centers under the state's Medicaid managed care program is strongly encouraged, but not mandated.

The state began experimenting with Medicaid managed care in 1983 and by the mid 1990s had significantly increased enrollment in such arrangements. State law requires that by 2000, 75 percent of all Medicaid beneficiaries in Colorado are to be enrolled in managed care, a goal that will pressure school-based health centers to secure contracts with the plans. The state's managed care statute lists centers as essential community providers (ECPs) with which health plans must make good faith efforts to contract, but this provision does not guarantee a contract, noted Guernsey. However, he believes the prospects for contracting are more contingent on good relationship-building than on legislative language.

The state has 31 school-based health centers serving about 34,000, or roughly two percent, of the state's school-aged children. Anywhere from 20 percent to 50 percent of children served in the centers are uninsured. About 20 of the centers have managed care contracts. The centers most successful at third-party billing are collecting revenues totaling about 25 percent of their operating budgets.

Contracting Opportunities: A school-based health center perspective. According to Deborah Costin, managed care consultant to the Colorado Association for School-Based Health Care (CASBHC) as well as the state health agency, there has been no problem in selling health plans on the concept of working with school-based health centers. HMOs recognize that children are in school and that the centers are great enrollment locations.

The payment arrangements across the 20 managed care contracts include fee-for-service and capitation. Under the state's Child Health Plan, Colorado's child health insurance program that predated SCHIP, school-based health centers receiving capitation by certain health plans are paid the same rate as other network PCPs and operate as full service primary care providers. Only school-based health centers open year-round qualify under this category. However, said Costin, other centers closed during the summer and during school holidays are operating under a partial capitation rate, in which the capitation is split between the school-based health center and its medical sponsor; this arrangement is occurring in a private experimental program sponsored by Kaiser Permanente called Kaiser School Connections.

"Demonstrating a commitment to meeting quality standards is crucial to cementing relationships" with managed care plans. -- *Deborah Costin*

"Demonstrating a commitment to meeting quality standards is crucial to cementing relationships" with health plans, she noted. Guernsey added that Colorado school-based health centers follow quality assurance standards established by the National Committee on Quality Assurance (NCQA)[9] and some clinical outcome measures that are based on the Health Plan Employer Data and Information Set (HEDIS)[10]. These outcome measures include completed immunizations by age six, completed Hepatitis B vaccines by 7th grade (a state requirement), and providing well-child visits to a certain portion of enrollees each year.

School-Based Health Centers and SCHIP. The state health department was heavily involved in designing the SCHIP legislation, including the benefits package and enrollment strategies, and in the process the department educated other agency staff about the role that school-based health centers could play. Because the department was concerned about access for rural areas where there is no managed care, it has allowed providers in these areas to contract directly with the state SCHIP agency for reimbursement, according to

Guernsey. Colorado has also requested a federal waiver to spend more than 10 percent of its grant on direct care provision using SBHCs. HCFA, however, has stated that funds under such waivers must be spent directly on children enrolled in SCHIP.

In addition, CASBHC has played an important role in SCHIP by developing certification standards plans can use to categorize centers along three levels of service intensity: Level 1 includes school-based health centers open every day and during the summer, with after-hours and weekend medical back up. These centers can operate as full-service PCPs. Level 2 defines the school-based health center as a co-manager of care with another organization that is open when the center is closed during the summer and holidays. Level 3 school-based health centers would operate as an add-on service; they must operate a minimum of three hours one day a week and provide at least primary care services including well-child care, immunizations, and family planning.

Contracting Opportunities: The view from managed care. Larry Wolk, medical director and vice president for health of Blue Cross and Blue Shield of Colorado, holds the rare distinction of being a managed care official with previous experience as a medical director of a school-based health center. He offered the following advice for centers interested in entering the managed care arena:

PARTICIPATE IN PREFERRED PROVIDER ORGANIZATIONS (PPOS) AND INDEPENDENT PRACTICE ASSOCIATIONS (IPAS). Wolk's plan, Blue Cross and Blue Shield of Colorado, made a commitment to contract with school-based health centers as part of its PPO network. PPO arrangements exist where insurance companies offer a fixed service rate to providers in return for allowing them to join their provider network. "You accept the rate, you're part of our network. Our kids can be seen in your school-based health centers." IPAs, or large group practices, are another entry point into managed care networks, according to Wolk. Health plans frequently contract with these practice groups, offering them a fixed monthly payment rate for providing hospital visits, outpatient, and urgent care. School-based health centers should approach the IPAs directly and ask to be credentialed as participating providers. But according to Costin, school-based health centers may face resistance in marketing themselves to IPAs because some view the centers as competing for patients.

EXPLORE SHARED RISK CAPITATION AGREEMENT. There may be a strategy for lessening the perception of competition on the part of network providers . Wolk recommended approaching primary care physicians in managed care networks and offering to serve their school-age enrollees for half the capitation rate. Some primary care physicians may not feel comfortable serving Medicaid beneficiaries and may be happy to share a per-member rate in exchange for providing case management. School-based health centers should market their experience and relationships they have developed in serving these young people and their families. Shared risk, however, does mean that if the cost of providing the enrollee care exceeds the monthly primary care capitation (on average in Colorado, $11 per member per month) the school-based health center must shoulder the extra costs of care.

More Advice From the Plans

Two officials from Los-Angeles based health plans -- Anthony Rodgers, chief executive officer for LACare, and Bruce Chernof, medical director for Health Net -- offered guidelines for school-based health centers seeking relationships with managed care plans. They emphasized the importance of provider stability and reliability and the providers'

ability to meet NCQA standards. On the first point, Chernof emphasized that plans need to know that contracting providers will not unexpectedly close their doors. The plans are responsible for assuring services to enrollees and if a provider shuts down it is the plan's obligation to find other providers for its enrollees. Regarding quality standards, NCQA is the market standard for health plans. Providers need to familiarize themselves with the standards and be able to meet them. At the same time, providers can sell themselves to plans based on their ability to help plans meet NCQA requirements. School-based health centers can, for example, help plans meet their quotas in such areas as well-child visits.

In addition to this general guidance, Rodgers and Chernof offered additional suggestions for the negotiation process:

Make problem-solving easier. A problem-solving forum that brings together plans and school-based health centers can develop common solutions that can be applied to the contracting process across the board. Such a forum reduces the time and effort providers must invest in building relationships with health plans to solve contracting problems. More importantly, it would reduce the frustration and time involved in rebuilding those relationships each time plans and school-based health centers experience staff turnover.

Learn what is important to the plans and how they structure their provider networks. Plans look for a common set of services from certain groups of providers. School-based health centers need to assess their capacity to serve as primary care providers, as urgent care providers, or as some other level of provider. The centers must also understand how plans pay providers and how they structure their provider networks. This knowledge will help centers in negotiating a place in the provider network.

Look for the win-win . Win-win situations are those in which a provider contract benefits both health plan and school-based health center. Here are a few of them:

- School-based health centers can help plans meet their NCQA access standards.
- Keeping parents at work is a marketing advantage for plans; school-based health centers need to remind plans of this benefit.
- School-based health centers can address health problems that are unattractive to office-based providers, such as treating head lice.
- School-based health centers can relieve Medicaid health plans of the cost of providing transportation for children served in the centers. (Transportation is a Medicaid mandated benefit. Under managed care, states often require health plans to provide it.)
- School-based health centers care for adolescents, a historically underserved population. Few health care providers reach this population well. Probably the most important service the centers can provide for adolescents is a face-to-face encounter that addresses high-risk behaviors.

Conclusion

The experiences of Colorado and Connecticut illustrate that school-based health centers *can* operate as part of managed care provider networks. The prospects for successful relationships appear to be higher when they are influenced by a strong state agency that requires or encourages the contracting process, and an effective state school-based health center association that can educate both its members and health plans about how the two can work in concert. The long-term viability of this new relationship is, however, uncertain. School-based health center participation in a market-oriented health system rests on a number of factors, most importantly their ability to meet managed care industry quality

standards and to clearly define themselves as valid and valuable candidates for provider networks. In addition, progress made in Colorado and Connecticut seems to be a function of all players in the contracting process sharing a commitment to success and of involving leaders from the public and private sectors with exceptional skills and vision. Whether additional states will bring similar levels of commitment and skills to this issue remains to be seen. As Medicaid managed care and SCHIP implementation progress, the capacity and desire of states, school-based health centers, and health plans to foster this relationship will become clearer.

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[1] 1998 State Survey of School-Based Health Centers sponsored by Making the Grade: State and Local Partnerships to Establish School-Based Health Centers and the National Assembly on School-Based Health Care. Report available from Making the Grade, The George Washington University School of Public Health and Health Services, #505, 1350 Connecticut Avenue, NW, Washington, D.C. 20036.

[2] Ibid.

[3] Schlitt JJ, Lear JG, Ceballos C, Chuckovich D, Hacker K, Hazzard K, Johnston K, Rosenthal B, and Zimmerman D. *School-Based Health Centers and Managed Care: Seven School-Based Health Center Programs Forge New Relationships*. Washington, D.C.: Making the Grade, 1996. See also Lear JG, Montgomery LL, Schlitt JJ, and Rickett KD. "Key Issues Affecting School-Based Health Centers and Medicaid," *J Sch Health*, 1996; 66(3):83-88.

4. In 1997 North Shore University Hospital (NY) reported Medicaid fee-for-service revenues covering 29% of its school-based health center budget; Montefiore Ambulatory Care Center (NY) reported Medicaid fee-for-service revenues totaling 67% of budget. Briefing paper prepared for Making the Grade program meeting, "Toward Financing School-Based Health Care: Expanding Covered Lives, Funding Uncovered Services," June 1997, Boston, MA. At the June 1998 Making the Grade/National Assembly workshop on SBHCs and SCHIP, Colorado SBHC officer Bruce Guernsey commented that a few SBHCs in his state are getting 25% of their operating budgets through Medicaid payments.

5. Health Care Financing Administration website, National Summary of Medicaid Managed Care Programs and Enrollment. July 27, 1998 www.hcfa.gov/Medicaid/trends97.htm.

6. Center for Studying Health System Change. Growth of Medicaid-Dominated HMOs. *Data Bulletin*, Number 11, Spring 1998.

7. Reschovsky J and Cunningham P. *CHIPing Away at the Problem of Uninsured Children*. Issue Brief # 14. Washington, DC: Center for Studying Health System Change, August, 1998.

8. Established under the Balanced Budget Act of 1997, SCHIP block grants are available to states to expand Medicaid eligibility for children, create a state insurance program that most likely would purchase coverage from the private market, or institute a combination of the two. Coverage is available for children under age 19 in families with incomes under 200 percent of the federal poverty level (80 percent of uninsured children fall below this threshold) or 50 percentage points above the state's Medicaid income limit as of August 22, 1997. For states using SCHIP to establish programs separate from Medicaid, sliding-scale co-pays can be applied to families with incomes over 150 percent of poverty. Aggregate premium and cost-sharing charges for all children in the family cannot exceed five percent of a family's annual income. For more information on the statute's requirements regarding minimum benefits standards, visit the HCFA webpage at www.hcfa.org.

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9. NCQA is an independent, non-profit organization that evaluates and reports on the quality of health plans. The NCQA Managed Care Organization Accreditation program is nationally recognized as an evaluation tool that health care purchasers, regulators, and consumers can use to compare health plans. NCQA employs six categories to evaluate MCOs: quality improvement, physician credentials, members' rights and responsibilities, preventive health services, utilization management, and medical records. For more information on school-based health centers and the NCQA accreditation process, as well as implications of HEDIS standards for school-based health centers, see the Making the Grade website at www.gwu.edu/~mtg.

10. HEDIS, sponsored by the NCQA, is a set of performance measures developed to provide health plan purchasers and users with information to compare the services and performance of various health plans. HEDIS measures are grouped under eight categories: effectiveness of care, access/availability of care, satisfaction with the experience of care, cost of care, stability of the health plan, informed health care choices, use of services, and health plan descriptive information.